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Family Planning Digest

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ACOG—1972

Women, Sterilization, Family Planning. Highlight 20th Annual Meeting

The twentieth annual meeting of the American College of Obstetricians and Gynecologists (ACOG) had several unusual features:

- Women told the specialists what they expected in fertility-related care, holding that doctors failed to move with the times.
- Obstetrician-gynecologists are taking an active lead in male sterilization programs.
- Highlights of family planning programs in various parts of the country were explored.
- A miscellany of reports dealt with the pregnant high-school-age girl, contraindications to prescription of the pill, a resolution by nurses on their involvement in pregnancy termination, and plans of ACOG to become more actively involved in the training of physicians in family planning.

Old Health Models No Longer Meet Need, Women Tell Ob-Gyns

In a reversal of the usual role, the patient—particularly the woman patient—took the spotlight away from the doctor and spelled out her health needs, including family planning, at the 1972 ACOG annual meeting. The main ballroom of the convention hotel was set aside for heavily-attended discussions and debates based on the theme, "What Women Want in Health Care," and the need for family planning was stressed repeatedly.

A key speaker was Charlotte Muller of the Center for Social Research of the City University of New York, who called for "a logically planned system of services related to [women's] fertility, so that from the time they begin to enter adult life they can have the children they want under the circumstances favorable for success." She accused the obstetrician-gynecologists of having practiced partly on the basis of outmoded concepts and urged them to reconsider their assumptions and to recognize "the significance of fertility as the basis of a new subsystem of services."

Muller said that the operation of the profession of obstetrics and gynecology had been based on several models.

- The medical model, originally related

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to infectious disease, in which . . . the patient is managed through an episode of disturbance. The criterion of successful performance is the termination of the disturbance. Even normal processes of childbearing have been approached in this manner. The study of normal human sexuality, with or without marriage, does not enter into the medical model. . . .

- The economic model, in which solo practice, fee payment and limited involvement of third party reimbursement to nonpoor patients on a per episode basis coexist with a clinic or program organization, session payment, and tax financing for care of the poor. The patient has no claim on continuous access to the same physician in many of the latter programs, even those of the greatest repute.
- The sociological model of marriage and the family, with courtship terminating in marriage at the end of the teens, some years of childbearing, and pursuits of women outside the household distinctly secondary to activities of the male head during a marriage of long duration.
- A psychological model . . . in which a competent and authoritative male practitioner is assisted by females of lesser training and is interacting with cooperative but less knowledgeable female patients.

The way of life incorporated in these models is being sharply challenged, Muller said, by the conviction that the consumer should have a say in developing health programs in this medical specialty. The medical model not only overburdens ob-gyn specialists but, more fundamentally, fails to provide women with the kind of planned fertility-related services "essential to all aspects of their satisfaction. . . ." The economic model, she said, is:

> obsolete with respect to its capacity to assure needed care to the disadvantaged. . . . Differential maternal and infant mortality associated with socioeconomic status and race indicates that clinical skills have been delivered through a system that has failed to solve major health problems of the population.

The marriage model is being exposed as an unreal portrait, Muller added. She pointed out that there is one divorce for every three new marriages, more than 31 percent of women over 18 are not married and women head one family in 10. "Not much is accomplished by a professional posture that all that is not contained in its philosophy is deviant; the need for health services that are adaptive is self-evident.

"The psychological model," she said, ". . . is due for a long-term shock as the . . . complaint woman may . . . recede completely to the past."

Once the profession recognizes fertility as the basis of a subsystem of services, she declared, "orientation to episodic care will yield to planning of components in such a way that appropriate referrals and consistent financial support will assure the service required by each woman for her chosen life roles in a given year."

Fertility control is a prerequisite for successful motherhood and "is essential in the search for self-realization in the occupational world," she emphasized. It is also intimately connected with good physical health.

Sterilization

Ob-Gyns Sponsoring Vasectomy Programs

Obstetrician-gynecologists are facing increasing requests for male as well as female sterilization and some are responding by actively directing vasectomy programs. In addition, it is predicted by some physicians that the question of whether obstetrician-gynecologists should actually perform vasectomies will arise more and more in the near future. (At the present time, ob-gyns specialize exclusively in the care of the female reproductive organs.)

This trend emerged when physicians presented reports of active vasectomy programs in Los Angeles, California, and Ann Arbor, Michigan. The ob-gyns in these communities are not performing the vasectomies themselves, but are playing a leadership role in the administration of such programs.

The average number of vasectomies at the University of Southern California Medical Center in Los Angeles was 12 a year until the Department of Obstetrics and Gynecology stepped into the vasectomy area two years ago, according to Dr. Robert Israel, Assistant Professor in the Department's Section of Reproductive Gynecology.

A survey taken at that time showed that 42 percent of requests for vasectomy were rejected by urologists, Dr. Israel said. It was felt by some physicians that sterilization should be considered part of family planning, he continued, and women patients increasingly began asking that their husbands be sterilized. Two physicians from the Department of Obstetrics and Gynecology became interested in starting a vasectomy program and a grant of $15,000 was obtained from the State Department of Public Health in July 1970. When that grant expired one year later, another grant of about $20,000 was obtained from the Los Angeles Regional Family Planning Council.

Working closely with the Urology Department, Drs. Gerald S. Bernstein and Harold H. Royaltey, together with Dr. Israel, all of them ob-gyn specialists, drew up the proposed vasectomy program. At the start, four vasectomies a week were done; the number is now eight per week, and 500 had been performed since July 1970. Twenty percent of the women who have babies delivered at the hospital do not want any more pregancies and are offered a choice of contraceptive methods as well as sterilization. They are told that sterilization is irreversible and are shown a film on the male and female procedures. If an interest in sterilization is expressed, both the husband and wife are interviewed to make certain they understand what is involved, and the acquiescence of both partners is obtained. Both the female and male procedures are offered. If the male procedure is chosen, three months after the vasectomy is performed a letter is sent to the couple asking their opinion about the operation and whether their sex life has been affected. Ninety-eight percent have replied that they are satisfied with the results.

Two sperm counts are done, one at one month after the procedure, and another at two months. A survey following the first 100 vasectomies and 50 tubal ligations revealed that 82 percent of the women and 66 percent of the men said the last pregnancy had been unplanned. Asked who should be responsible for birth control methods, 55 percent of the men said that both husband and wife should be equally responsible. Codirectors of the vasectomy clinic are Dr. Bernstein and Dr. Robert Mendez, a urologist.

The Michigan report was made at the meeting by Dr. William Ledger, Medical and Research Director of the Washtenaw County League of Planned Parenthood, and Associate Professor of Obstetrics and Gynecology at the University of Michigan Medical

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Center. Dr. Ledger said that two years ago, after the Nelson Committee hearings on oral contraception, many couples began to ask for alternative contraceptive methods. A vasectomy program was begun under the auspices of the League, in cooperation with the Department of Obstetrics and Gynecology of the Medical Center. As Dr. Ledger explained, "We had an active group of urology residents at the Center, and, in June, 1970, we opened the first evening vasectomy clinic, planning to provide four vasectomies per week." (During the day, the Center facility is used as a prenatal clinic; the space is rented by the League at night for use as a vasectomy clinic.)

Within a week, the vasectomy clinic was deluged with 400 requests for vasectomies. The number of vasectomies rose from four to 10 a week in August, to 20 per week in September, and by January 1971, had reached 40 a week. Through March 7, 1972, a total of 2,605 vasectomies were performed.

The clinic at Ann Arbor can do up to 80 vasectomies per week, with the procedures performed by the urology residents who are supervised by the Medical Center staff. Dr. Ledger noted that the ob-gyns on the League's medical board, as well as urologists at the Center, had been interested in trying to meet the demand for vasectomies. "We ob-gyns recognized the need, and set the stage, but of course, we didn't tell the urologists how to do vasectomies," Dr. Ledger told *Family Planning Digest*. "All obstetrician-gynecologists are facing increasing demands for sterilization, and it's important for them to know what is facing them. It's very logical, and in many instances, it is far better for the male, rather than the female, to be sterilized."

Dr. Ledger predicted that the question of whether the obstetrician-gynecologist will be involved in performing the procedure will be increasingly debated. The bylaws of the American College of Obstetricians and Gynecologists now restrict the membership to maternal procedures. "What if there's no urologist in town—what should the obstetrician-gynecologist do then?" Dr. Ledger asked.

Four Programs Singled Out for Excellence in Medical Care, Training, Education, Outreach

Four family planning progams were hailed as among the best in the country by Dr. Carl W. Tyler, Jr., Chief of the Family Planning Evaluation Branch of the Epidemiology Program, Center for Disease Control in Atlanta. A University of Mississippi family planning project was singled out as "unique" for its quality of medical care, an Indiana program for its social work component, Harlem Hospital in New York for its exceptional educational approach and the Frontier Nursing Service in eastern Kentucky for its incorporation of family planning in overall maternal and child care.

Dr. Tyler observed of the University of Mississippi Medical Center program:

> [the] supervision and training of physicians, as well as medical students, in the family planning program, is closer and more detailed than any I've seen. They have done this by insisting that each doctor who works in the clinic go through a preceptorship, with supervision of his family planning procedures. One of the fulltime doctors looks over his shoulder at a nearby clinic, which is outside the Medical Center, and there is always a fulltime physician available for consultation. They also hold additional workshops and training courses for surgery, such as laparoscopy, both at the Center and at the nearby clinics.

Dr. Tyler praised the Indiana program for its incorporation of a social worker staff and for the "very strong continuation" aspect of its program. The Indiana program has a social worker who provides "strong leadership" and who assumes responsibility for outreach workers. "She has trained outreach workers to do case finding, and to do a certain amount of referral," Dr. Tyler noted. "Outreach workers assist with the screening and then the social workers assigned to the family planning program actually do the case work. For a family planning program to have this much strength is unusual."

Harlem Hospital was lauded for its high-quality family planning educational program. Dr. Tyler praised a video tape technique which has proved effective, and also "Operation Total Family," an educational program in which teenagers are contacted both in the schools and in a special center, so that they can obtain counseling. In the video tape program, postpartum and postabortal patients view a video film, "Family Planning, A Matter of Choice," in booths in a lounge at the hospital. The film explains sexual anatomy and physiology and methods of contraception, and the booth is equipped

Marriage Applicants Get Birth Control Data

Virginia has joined Hawaii and California in providing for distribution of birth control information by "every person who is empowered to issue a marriage license" to couples applying for them. Under a recent bill signed by Governor Linwood Holton, couples will be given birth control information and a list of family planning clinics in the county or city of the issuing office. It has been estimated that about 52,000 Virginia couples will receive such information annually. The state department of health is responsible for furnishing the data.

Hawaii's law authorizes health departments to give applicants for marriage licenses information "relating to population stabilization, family planning and birth control." California's health and safety code states that the county health officer shall prepare a list of family planning clinics to be distributed to couples by the county clerk.

Sources

Code of Virginia, § 20-14.2.
California Government Code, § 26808 (Suppl. 1971).
California Health and Safety Code, § 463.

with a button the woman can press to have questions answered. In "Operation Total Family," staff members conduct rap sessions with adolescents, discuss family planning with girls in junior and senior high school and also do individual counseling.

The Frontier Nursing Service, Dr. Tyler said, is "legendary" for its accomplishments. It has been offering contraceptive service since 1957, when virtually the only female methods were the diaphragm and jellies. The nurse-midwives of the Service, he continued, introduced IUDs in 1961 and succeeded in launching a combined family planning and baby clinic.

A detailed report on the Frontier Nursing Service was given by Dr. W.B. Rogers Beasley, its Medical Director. Between 1960 and 1970, a period in which the nurse-midwives were carrying out an intensive family planning program in a three-county area of 180,000 population, the number of births decreased by 30 percent and the birthrate decreased by 60 percent. (In the middle of the 1950s, deliveries totaled more than 500 babies a year in the Frontier Nursing Service; the area had the highest reported birthrate in the country.)

During a debate on whether the American nurse-midwife can provide complete maternity care, Dr. Bruce D. Stern of Beverly Hills, California, declared that to return to midwifery would be "a giant step backward." However, in his report, Dr. Beasley noted that in the first 10,000 deliveries, most of which were in the home, the rural nurse-midwives in the Frontier Nursing Service achieved a maternal mortality rate of 11 per 10,000 live births, in comparison with a national rate at the time of 34 per 10,000 live births. In the past 20 years, there have been no maternal deaths in the population covered by the Service.

The Indiana program was described by Dr. Joseph F. Thompson, Director of the Division of Population Dynamics and Family Planning at Indiana University. He said that the growth of services in the program was reflected in the increase from an initial budget of $25,000 in 1968 to the 1972 statewide budget of $1.2 million. The program began in 1968 in the Marion County General Hospital, which was affiliated with the University. By 1972, Dr. Thompson said, there were 11 family planning projects in operation in the state.

Dr. Thompson pointed out that the university's ob-gyn department administered a federally funded project that provided family planning services in 1971 for 14,062 patients. The average cost per patient ranged from $11 at a large hospital-based project to $120 at a small project.

Dr. George Huggins, Assistant Professor in the Department of Obstetrics and Gynecology, and Director of Family Planning at the University of Mississippi Medical Center in Jackson, reported that the department made a commitment to provide family planning services for the community in December 1970. At that time, about 1,180 women of the estimated 9,500 in need were receiving "sporadic, uncoordinated" family planning services from several agencies in the county. Dr. Huggins noted that the University of Mississippi Medical Center provides "essentially the only hospital-based maternity care available to the poor in the city of Jackson and in Hinds County."

Among the steps taken to provide services, the Ob-Gyn Family Planning Division of the Medical Center recruited a licensed practical nurse and two nonprofessional women and trained them to give education and information to all antepartum, postpartum and postabortal patients in the Center.

One of the most significant aspects of the program is the relationship of the staff with the patients, Dr. Huggins said, adding, "We're beginning to show resident physicians that if you treat poor people the way you treat rich people—with respect and dignity—they'll respond the same way."

Dr. Donald P. Swartz, Director of Maternal Services at Harlem Hospital, reported that family planning services began early in 1963. "We evolved somewhat accidentally through a series of different personalities and modalities," he noted. By January 1965, "we were able to offer all services." In 1971, community-based education was begun.

Dr. Swartz explained that the Harlem Hospital-Harlem Neighborhoods Association family planning program, "Operation Total Family," is an outreach program which involves almost daily sessions in the community. Club groups for counseling, consisting mainly of adolescent and preadolescent youngsters, meet separately in a Harlem center. Sex education is offered at other sessions to girls reaching puberty. On Thursdays, rap sessions, thrown open to all types of questions, are held for adolescents. In addition, sex education programs, on different levels, are presented at two elementary and several junior and senior high schools.

Other ACOG Highlights

• In a session on hormonal contraception, Dr. John E. Tyson, Associate Professor of the Department of Obstetrics and Gynecology at The Johns Hopkins University School of Medicine, warned that women with a history of gestational diabetes or those taking oral hypoglycemic pills to correct a low blood sugar deficiency should not be given the oral contraceptive. "An initial benefit in taking the [contraceptive] pill is followed by a deterioration over six to eight months in those women who have a heritable predisposition to islet cell dysfunctions of the pancreas," he said. "These women should be screened before contraceptive pills are prescribed."

• A resolution by the Nurses Association of ACOG stated that nurses have the right to "refuse to assist in the performance of abortions and/or sterilization procedures in keeping with their moral, ethical and/or religious beliefs, except in an emergency when the patient's life is clearly endangered. . . ." This refusal, the resolution continued, should not jeopardize the nurses' jobs.

In dealing with such patients, according to the resolution, nurses should not "impose their views on the patients or personnel." Nurses should inform employers of their views on abortion and sterilization, while employers should inform the nurses of the hospital's policies and practices on abortion and sterilization, the resolution said.

• ACOG's Division of Family Planning has obtained $300,000 from the National Center for Family Planning Services of the Department of Health, Education and Welfare, to establish training programs for graduate physicians and information for undergraduate medical education in the family planning field. Dr. Louise B. Tyrer, director of ACOG's Division of Family Planning, said that the programs will be established in institutions in each of five regions—East, South, Midwest, Southwest and West Coast. Two five-day training seminars will be held in each institution during the year, with attendance at each limited to 25 physicians. "We anticipate that an additional program to teach laparoscopic tubal sterilization will be funded," Dr. Tyrer said. "This will be available to those who have had surgical background, and will be presented in two five-day seminars, to be held in only one of the five institutions during the year."

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G. R. Huggins, M.D., "The Attempt of a University to Cope with Community Need."

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Nurses Association of the American College of Obstetricians and Gynecologists, press release, May 3, 1972.

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L. B. Tyrer, M.D., personal communication.

J. E. Tyson, M.D., personal communication.

Childraising Costs

About $98,000 Needed To Take First Child From Birth to B.A.

An average U.S. family must spend about $40,000 in direct costs—from hospital delivery through college graduation—to raise its first child, and more than $98,000 if the mother's lost earnings (opportunity costs) due to her withdrawal from the work force for childbearing and rearing are taken into account. For each additional child, costs average about $48,800 in direct and opportunity costs combined.

These were the main findings of a study, "Costs of Children," prepared by the late Ritchie H. Reed and Susan McIntosh for the Commission on Population Growth and the American Future.

In addition to direct and opportunity costs, the study noted that premarital pregnancy, birth timing failures and unwanted births "are also detrimental to future family progress. . . . Thus, the direct and opportunity costs of planned children can be aggravated by unwanted or poorly-timed births, which have important effects on a family's ability to progress economically." [The authors point out that $98,000 is the undiscounted total cost of raising a first child—that is, the actual direct cost, assuming that no interest ever is accumulated on the money. But these costs do not occur all at once; they are spread out over a period of years. If all the money needed to raise the child were available before the infant's birth, then interest could accrue on it, or portions of it, even while other portions of it were being spent. From this can be derived a discounted cost (assuming an annual interest of eight percent on the unspent portion of the money) of about $60,000 to raise a first child, with additional children costing about $29,000 each.]

The authors include in direct costs all dollar costs for delivery, housing, food,

education, clothing, medical care, transportation and other maintenance expenses. Using U.S. Department of Agriculture "moderate cost" estimates for raising a child to the age of 18, the investigators found little difference in dollar estimates by region or by degree of rurality—with such costs averaging about $33,000. Their cost estimate for childbirth—$1,534—came from a Blue Cross estimate for hospital and medical care, nursery supplies and maternity wardrobe. Based on Department of Health, Education and Welfare statistics on costs of higher education, the authors estimated that an average family spent $5,560 on tuition, fees, room and board.

Opportunity costs—that is, the earnings that a woman might have had, but had to forego in order to bear and raise children —were found to vary significantly with the level of education of the woman. Thus, the average opportunity cost for the first child was estimated by the authors at about $39,300; but this ranged from a little less than $30,000 for women with an elementary education to $69,000 for women who had an education beyond the college degree.

"These differences in opportunity costs by educational level partly explain the lower level of fertility among the highly educated," the authors commented. "Children 'cost' them more and they have fewer of them."

Discussing the opportunity cost to the mother, the study pointed out that "not only does the mother give up money that she might have earned, but she also gives up other satisfactions that would accompany a well-paying satisfying career." The authors observed that "not all women would want a career or job, even if they did not have children. To some, the pleasure of parenthood far outweighs the money foregone due to having children. For other women, however, the loss of earnings is a relevant consideration." The average total cost of a child is shown in Table 1.

Table 1. Average Total Cost of a Child, 1969

	Discounted	*Undiscounted*
Cost of giving birth	$ 1,534	$ 1,534
Cost of raising a child to age 18*	17,576	32,830
Cost of college education	1,244	5,560
Opportunity costs for the average woman†	39,273	58,437
Total costs of a first child	**$59,627**	**$98,361**
Marginal cost for each additional child spaced two years apart	$28,924	$48,793

* U.S. Department of Agriculture "moderate cost" level.

† Depending on the educational background of the mother, the opportunity costs (earnings foregone by not working) could be higher or lower.

The authors pointed out that the figures include a number of assumptions: "First, tastes and preferences must remain constant," they said. "That is, we are assuming that normal purchases for a 12-year-old child in 1961 are normal purchases for the same age child in 1971 and vice versa. Second, we assume that the standard of living of a couple will remain constant while their children are growing up. Thus, we are ignoring increases in real income which are the typical experience of most American families."

That premarital conception appears to have unfavorable economic consequences for the couple's life is revealed by a study of Detroit white mothers in 1961 which showed that those couples with lower incomes have a much higher incidence of premarital pregnancy. Following up the same sample in 1966 indicated they were "still significantly worse off . . . than those couples who had not been premaritally pregnant." Other characteristics of couples having premarital conception include earlier marriages and fewer years of school completed. ["Couples Best Off Who Best Plan Number and Spacing of Children," *Digest*, Vol. 1, No. 3, 1972, p. 3.]

Close spacing and unwanted births are other factors influencing lower economic levels. Thus, "'short spacers' not only have their children at shorter intervals, but have more of them," the study noted. The unwanted births are more difficult to pin down, because many mothers are reluctant to admit that a child was unwanted. Studying the effect of unwanted births on family income, the study found that each unwanted birth, on an average, reduced family income by about $258 per year. Although for some income groups this is not high, for others it is much more serious, since in a family with $2,500 per year income (and 1.23 average unwanted births), the loss as a percentage of the total income can be 15.6 percent.

"As a result of the depressing effect unwanted births have on family income and the prevalence of unwanted fertility at the lower income levels, unwanted births contribute substantially to what is officially defined as poverty," the authors said. "According to our calculations, if there had been no unwanted pregnancies in 1965, there would have been 21.2 percent fewer white families and 33.1 percent fewer white individuals in poverty." For blacks, they added, "without unwanted births, there would have been 42.9 percent fewer black families in poverty."

Source

R. H. Reed and S. McIntosh, "Costs of Children," in E. R. Morss and R. H. Reed, eds., *Economic Aspects of Population Change*, Vol. 2, Research Papers, Commission on Population Growth and the American Future, U.S. Government Printing Office, Washington, D.C., 1972 (in press).

Unwed Teenagers

28 Percent Have Had Sexual Relations: Half of These Used No Contraception

About three in 10 never-married girls of high school age have had sexual intercourse, but only about half of those who are sexually active attempted in any way to prevent a pregnancy during their most recent sexual experience. Of those who did attempt birth control, only about one-fourth used the most effective methods—the pill and the IUD—and 34 percent used methods that are considered extremely ineffective among this group—withdrawal and douching. Only 37 percent of 15-19-year-old sexually active girls used chemical methods or conventional contraceptive devices at the time of their most recent sexual experience.

Nearly one in five of those using no contraception failed to take precautions because they were uninformed or misinformed about the risk they ran of getting pregnant. Adding those who failed to use birth control because they thought it was not the time of the month when they could become pregnant—among whom mistaken notions about the 'safe' period were quite prevalent—brings this category of risk-takers to 56 percent. Another 14 percent said they didn't have contraception available, didn't know about it or didn't know where to get it. About 15 percent said that they didn't mind having a baby or were actually trying to get pregnant.

These were some of the major findings reported by Melvin Zelnik and John F. Kantner of The Johns Hopkins University's Department of Population Dynamics in a research paper prepared for the Commission on Population Growth and the American Future. The paper was based on a survey undertaken by the authors in 1971 of a national probability sample of the U.S. female population aged 15-19. The survey involved 4,611 interviews conducted by the Institute for Survey Research of Temple University.

The researchers reported that although 72 percent of all 15-19-year-olds in the survey were virgins, this ranged from 86 percent of 15-year-olds to 54 percent of 19-year-olds.

Most of the sexually active females have had intercourse with only one partner, and thus, the investigators noted, "the picture is not one of rampant sexuality among the sexually experienced. Monthly frequency tends to increase with age," they said. "At age 15, three-quarters of the sexually active females have intercourse less than three times per month. At age 19, slightly over half are so classified."

In studying data on contraceptive use, the investigators found that the "most significant observation . . . is the pervasiveness of chance taking. At any age . . . those who never used contraception plus those who have sometimes failed to use it constitute a solid majority."

Respondents' belief that they could not become pregnant was in large part a result of "widespread misconception about the period of greatest pregnancy risk." Less than 45 percent of the sexually active girls knew that pregnancy risk was greatest midcycle.

Almost all of the girls surveyed had at least heard about the pill, whether they had sexual experience or not; and, among the sexually active at least, the vast majority had heard of most other methods, too. An exception was the IUD. Even among the sexually active girls, one-third had never heard of it.

About 60 percent of the girls started using contraception at the same age at which they became sexually active—the rest waited until later.

As the girls grew older, there was less reliance on the use of the condom together with increased use of the pill. Thus, less than five percent of 15-year-old contraceptors were found to use the pill and 30 percent to use the condom. By age 19, 40 percent were using the pill and 21 percent the condom. The authors note that "the condom . . . retains a fair degree of popularity despite the marked inroads of oral contraception."

Two-thirds of the girls who used birth control said that they obtained their contraceptives from the drugstore. About one-fourth said that they obtained contraception from a physician, either from a private doctor or through a clinic.

The survey found that 18 percent of all the sexually active unwed girls had had a pregnancy. Of those who had been pregnant, 61 percent had borne a child; the others either were currently pregnant for the first time or had failed to deliver a live birth because of a miscarriage, stillbirth or abortion.

Four percent of the sexually active girls were pregnant at the time of the survey. Only 20 percent of those pregnant at that time who had not wished to become so, had used contraception regularly. The authors noted that abortion was not contemplated by these girls.

Source

M. Zelnik and J. F. Kantner, "Sexuality, Contraception and Pregnancy Among Young Unwed Females in the United States," in C. F. Westoff and R. Parke, Jr., eds., *Demographic and Social Aspects of Population Growth*, Vol. I, Research Paper, Commission on Population Growth and the American Future, U.S. Government Printing Office, Washington, D.C. 1972 (in press).

JAMA Editorial

Caution on Vasectomy Sounded by Doctor

Vasectomy, while a safe, efficient and inexpensive method of limiting family size, should not be considered casually by either the patient or the physician, according to Dr. Harold Lear, Fellow in Community Medicine at The Mount Sinai School of Medicine in New York.

Pointing out that in 1970 sterilizations increased substantially in the United States, accompanied by a growing demand for vasectomy, Dr. Lear emphasized the physician's responsibility in an editorial in the *Journal of the American Medical Association*. "No surgical procedure which results in severe impairment or loss of a major body function should be undertaken casually," he wrote.

Dr. Lear emphasized the "probable irrevocability" of vasectomy, and the possibility of autoimmunity to his own sperm developing in a vasectomized person. "With one out of every three marriages ending in divorce," he observed, "the possible irreversibility of the sterilization assumes another dimension."

Some physicians perform contraceptive vasectomies "on request," while others insist on a stable family unit, at least two children in the family, personal interviews, psychiatric evaluation and consent of husband and wife, he said. Dr. Lear wrote that the "vast majority of men seeking sterilization are emotionally stable and desire contraceptive vasectomy for mature and rational reasons," but he warned that "the exacerbation of psychiatric problems postoperatively is not uncommon in patients with a history of sexual dysfunction or emotional instability." He concluded: "Although contraceptive vasectomy is an ethical procedure, the physician is not absolved of his responsibility to evaluate surgical indications cautiously and to obtain the *informed* consent of the patient."

Source

H. Lear, M.D., *Journal of the American Medical Association*, **219**:1207, 1972.

Cost Effectiveness

$66 a Patient Annual Family Planning Cost

It costs an average of $66 per patient per year to provide family planning services in programs funded by the National Center for Family Planning Services (NCFPS), according to a study made for NCFPS by the Westinghouse Population Center of Columbia, Maryland. The range of costs, however, was considerable, from $28 to $188.

The study was made of a stratified sample of 24 NCFPS grantees, comprising 39 provider agencies, drawn from 125 grantees for which comparable background information was available. Site visits were begun in October 1971 and completed in February 1972. Agencies were classified according to: size of budget; age of program; location of project (metropolitan-nonmetropolitan); current patient load; type of clinic (family planning only or multipurpose); and regional location. The researchers found that the "two most important factors which influence a program's operation are size of budget and age."

In general, the Westinghouse researchers found that per patient costs were lower in medium-budget ($100,000-$390,000 per year) than in big-budget programs (more than $390,000) or low-budget programs (less than $100,000).

Recently established programs had significantly higher per patient costs than more mature projects, presumably because of start-up costs. This was particularly true of the large programs. Those more than two years old showed average per patient costs of $49 per year—considerably below the $66 average—while those only a year or two old cost an average of $124 — almost twice the national average. This, the researchers pointed out, is because large young programs do not have the organizational maturity to handle the large resource base. The researchers did not find it surprising that small programs had higher per patient costs than big- and medium-budget programs because the smaller programs, with fewer patients, could not take advantage of economies of scale. "The greatest surprises," the researchers said, "came from the conclusions that age does not affect the cost of medium-size programs, and that they cost the same [statistically] as large old ones [$69 vs. $49]."

In light of this finding, the researchers suggest that "the optimum funding strategy is to start a program in the medium [budget] range and not to increase its funding significantly until the program has matured . . . ," that is, wait until the program is at least two years old. They add, however, that their "conclusions do not imply that large state-wide programs should be avoided. Indeed, if they are composed of several medium-size separable service providers, they should be as efficient as if each had been funded separately."

The average cost of recruiting a new patient (outreach) was found to be $26 (ranging, however, from $5 to $105), while the cost of retaining a continuing patient (follow-up) averaged only $8.50 (again, however, the range was very considerable—from $2 to $104).

There were more programs in the sample with higher patient costs than with lower patient costs. Thus, the average program in the system was spending $78 rather than the $66 overall per patient per year average. Other per patient program costs were: pill, $73; IUD, $97; diaphragm, $71.

The researchers found that total program costs were not much affected by organizational affiliation (Planned Parenthood, health department or hospital) or method of service delivery (freestanding facility, mobile team or postpartum program).

The Westinghouse researchers noted that the average program cost about $314,000 a year (ranging from $60,000 to $1.25 million); it served 5,000 patients annually (ranging from 480 to 12,980 patients); more than 2,700 of these (ranging from 445 to 8,716) were new patients seen for the first time. The average patient made a little fewer than two visits per year, and the average program provided services to its patients during 54 clinic sessions per month at eight clinic sites—but the ranges were great.

The average program spent about 42 percent of its total costs for direct provision of family planning medical services, 21 percent for educational and social services, four percent for community involvement activities, and the remaining 33 percent for management and administration (including overhead and facilities costs). Total costs included not only budgeted costs but estimated value of volunteered, donated or otherwise provided services, supplies, equipment and facilities.

The largest single cost category—nearly two-thirds of the total — was for personnel. On the average, the researchers found about two-thirds of the personnel cost was paid to people working for the program on a full-time basis.

Personnel cost, as a proportion of total cost, tended to decrease as the programs increased in size. Volunteer personnel accounted for about six percent of the total cost.

Some significant differences were found between the Planned Parenthood groups (typical of the single-purpose family-planning-only programs) and the health departments (typical of the multipurpose agency—family planning plus other health services):

- The Planned Parenthood groups had a much larger number of clinic sessions per month than health department (or other) agencies of similar size (67 vs. 33).
- Planned Parenthood affiliates devoted considerably more full-time personnel to their family planning projects than did health departments. More than three-fourths of Planned Parenthood staff was full-time, compared to about 54 percent in health departments.
- Planned Parenthood groups were found to keep more comprehensive and more complete records of their services than health department (or any other) service providers.
- Compared to health departments, Planned Parenthood groups spent a smaller proportion of their total cost for direct provision of medical family planning services, and a larger proportion for community involvement and for administration. Because of Planned Parenthood groups' single-purpose structure, the researchers pointed out, they "cannot spread . . . management and administration time over several programs. . . . Similarly space and equipment costs are applied solely to the family planning program; they cannot be shared with other projects."

These differences, it was found, "do not affect the overall cost of providing services."

The programs sampled were in: Columbus, Toledo, and Dayton, Ohio; Gainesville, Savannah and Augusta, Georgia; East Orange and Newark, New Jersey; Fort Worth and Eagle Pass, Texas; Seattle, Washington; Hartford, Connecticut; Tucson, Arizona; Syracuse, New York; Kansas City, Missouri; San Jose, El Centro, Ventura and San Bernardino, California; Boise, Idaho; Wilmington, Delaware; West Palm Beach, Florida; Indianapolis, Indiana; Flint, Michigan; and Tulsa, Oklahoma.

Source

Comprehensive Report: Cost Study of a Sample of the Grantees of the National Center for Family Planning Services, HSM 110-71-219, Westinghouse Population Center, Columbia, Md., 1972.

Services by Yacht

How do you bring family planning services to thousands of persons living on remote islands scattered over two million square miles of the Central Pacific Ocean? By yacht, of course. Faced with this challenge, the International Planned Parenthood Federation reports, British administrators in the Gilbert and Ellice Islands chartered a 180-ton motor yacht to take family planning workers and supplies to the outer islands. During a recent five-week tour, the vessel traveled over 2,000 miles, enabling nurses to visit previous acceptors and to serve new patients. Four more tours of one month each are planned.

Source

"Yacht Takes Family Planning to Pacific Islands," *IPPF News,* No. 211, Oct. 1971.

Male Attitudes

U.S., Chilean Men Say 'Family Planning Yes'. Want More Contraceptive Education Services

Men, too often forgotten in studies of family planning attitudes, knowledge and practice, have been found to be overwhelmingly in favor of planned families and increased male responsibility for birth control, in studies conducted in the United States and Chile.

Nine out of 10 (88 percent) Pittsburgh fathers interviewed in 1971 said that family planning services should be made available to men; 84 percent said they favored planning the size of their families, and 83 percent believed that "the government should put more effort into providing voluntary family planning services." Nearly six out of 10 of the men queried said they would take a birth control pill if one were available for men.

When asked how many children they desired, the general trend was to specify two or three children, but 40 percent said they desired four or more. Thirty-three percent of white fathers in families with incomes of $5,000 or less annually said they wanted four or more children, compared to 50 percent of blacks in that income group. However, differences between color groups on this item disappeared once family incomes rose to $6,000 or more.

Nearly two-thirds of the men said that continued population growth in the United States could lead to food, space and other resource shortages, and nearly half (46 percent) thought the government "should put more effort into controlling population growth." However, they were emphatic in opposing government efforts which went beyond voluntary family planning. Seventy-three percent said that "government regulation of family size is an invasion of privacy"; 59 percent said that "the number of children a couple has is no one's business but their own," and only 11 percent favored taxing families for each child they had in excess of four.

The study was reported at the National Conference on Social Welfare in Chicago on May 31 by the principal investigators, Dr. William H. Spillane, of the Behavioral Sciences Branch of the Center for Population Research of the National Institute of Child Health and Human Development, and Paul E. Ryser, of the Graduate School of Public Health of the University of Pittsburgh.

The study was conducted through evening group interview sessions. The fathers were men under 60 whose incomes averaged $6,646. The wives were between the ages of 20 and 45. At least one dependent child lived in each family. The white fathers had an average annual income of $7,064, and the black fathers, $5,482. The group was 74 percent white, 26 percent black, 37 percent Protestant, 42 percent Catholic, seven percent Jewish and 14 percent "none or other" religion.

In Chile: Family Planning, "Si"

In another survey—the first attempt to examine opinions of Chilean men about family planning—it was found that a majority of some 800 Chilean men believed that information on family planning is valuable to themselves, other adults and to adolescents. They also favored educational programs in contraception for young people of both sexes.

The Chilean findings were reported by Dr. M.-Francoise Hall, Assistant Professor in the Department of International Health at The Johns Hopkins School of Hygiene. For the study a sample of men between the ages of 18 and 54 in the capital city of Santiago, and in María Pinto, a nearby rural area, were personally interviewed. The sample population in Santiago—which finally totaled 584—was broken down into three socioeconomic levels: lower, middle and upper. In María Pinto, the final sample of 217 men, selected to provide a contrast to the city group, represented all men in the area and was on a lower socioeconomic level than the "lower" level in the city.

The study revealed that 56 percent of the men in the rural area, and 58 percent in the lower socioeconomic group, and from 73 to 81 percent in the middle and upper levels in Santiago, favored contraception for themselves. Asked whether they approved of giving contraceptive information to any married woman, 54 percent in the rural area replied affirmatively; in Santiago, the affirmative reply was 71 percent among lower-level men and from 84 to 91 percent among middle- and upper-level men. An even larger proportion favored providing contraceptive information to any married man: 62 percent in María Pinto, and from 75 percent among the lower socioeconomic group to 87 to 94 percent of the middle and upper groups in Santiago.

Although approval of contraception was widespread, its actual use was by no means universal. Only 35 percent of villagers between 25 and 54 years of age said that they or their wives were "using a method or doing something in order not to have a pregnancy." A much higher percentage of urban dwellers sampled, however, reported that they were trying to prevent pregnancy. About three-quarters of upper-level men, and from 49 to 59 percent of lower- and middle-level men, said that they or their wives were attempting to control their fertility. Fewer than half (48 percent) of the villagers, compared with from 61 to 93 percent of husbands in Santiago, had used some means to try to avert pregnancy in the three-month period before the interviews took place.

A majority of the men pictured themselves as vitally concerned with making decisions about contraceptive use and family size. Seventy-two percent of the village husbands felt that both husband and wife are equally concerned about the number of children in the family, while from 58 to 66 percent of urban husbands believed this to be the case. An additional 11-15 percent of the men felt that men were even more concerned.

Among unmarried men, about one-quarter of village respondents said they believed the decision to use contraception should be made jointly by husbands and wives. There was a sharp difference among urban respondents, however. About 75 percent of unmarried upper-level men believed this should be a joint decision, compared with from 30 to 36 percent of lower- and middle-level men.

At all socioeconomic levels, more men favored giving contraceptive information to higher percentages of men—married or single—than to married and single women.

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Fertility Society

Human Fertility and Infertility Explored By Nation's Reproductive Scientists

Human fertility and its control as well as human infertility and its cure were reported upon by clinicians and research scientists at the twenty-eighth annual meeting of the American Fertility Society held in New York City Feb. 28-March 1. Of special interest to family planning workers were reports: of a combined oral contraceptive containing substantially less estrogen than presently marketed pills but with as high a degree of effectiveness; of a new surgical technique and new technology which promise greater success in reconstructing ligated fallopian tubes; of continuing debate over autoimmune sperm response following vasectomy; of the possible luteolytic effect of prostaglandins; of long-term follow-up of women who had been sterilized; of the incidence of early medical complications following legal abortion in the United States; and of the ethics of human experimentation.

Orals

Half of Estrogen Dose Prevents Pregnancy

A collaborative clinical study of 3,803 women in 12 cities indicates that pregnancy can be prevented with 40 to 60 percent less estrogen than is now used in marketed combined oral contraceptives, according to Dr. Stephen N. Preston of the Department of Clinical Investigation, Parke, Davis & Co., Ann Arbor, Michigan. The report aroused considerable interest in view of studies which have suggested a direct relationship of estrogen dosage to the occurrence of thromboembolic disease.

While the reduced dosage was effective in preventing pregnancy, irregular bleeding patterns were reported at rates higher than those in which the higher estrogen dosages are used. The altered cycle patterns were acceptable to about 90 percent of the women studied, Dr. Preston said. He added that the reduced estrogen dosage also succeeded in effecting a "marked reduction" in side effects, such as nausea, headache and sore breasts, and said that this reduction in side effects "would seem to offset the inconvenience of cycle irregularity."

It had been anticipated that the pregnancy rate would increase as the estrogen dose was reduced, Dr. Preston said. Instead, the rates thus far established in the study, 0.15 to 0.17 per 100 woman-years, "do not differ significantly among the formulations studied nor are they appreciably different from those reported for approved formulations in present use," he stated. "This unexpected observation indicates that fertility control can be maintained, probably through pituitary suppression, by considerably smaller doses of estrogen than are presently employed."

The physician explained that in order to minimize the number of variables to be studied, it was decided to use "reduced doses of marketed products of proven efficacy, maintaining the same progestin-to-estrogen ratios and the same dosing regimen." He explained that this approach "obviated the necessity of massive laboratory testing since safety for higher dosage products had already been established." Dosages used in the study were: norethindrone acetate and ethinyl estradiol in the following proportions, respectively: 2.0 mg/40 mcg; 1.5 mg/30 mcg; 1.0 mg/20 mcg; and 0.6 mg/30 mcg. Dr. Preston said that the "incidence rates of irregular bleeding tended to decrease during the first three cycles and then level off." The 2.0/40 regimen was discontinued early in the study in order to concentrate on the other three dosages. Dr. Preston noted:

> From previous experience women would seem to be programmed to accept up to seven days of total bleeding during each 28-day cycle . . . The percentages exceeding seven days during cycle one are 18.0 percent and 18.6 percent, respectively, for the 1.5/30 and 1.0/20 formulations, and 32.1 percent for the 0.6/30 formulation. By cycle three these percentages have decreased to 10.0 percent, 13.6 percent and 16.7 percent. With increase in cycle experience, these percentages continue to decrease.

The collaborative dose-response study included investigators in Portland, Oreg.; Philadelphia; New York; San Francisco; San Antonio; Pasadena; Minneapolis; Los Angeles; Columbus, Ohio; Davis, Calif.; Detroit; and Honolulu. The study, started June 6, 1970, is continuing.

Discuss Sterilization Advances, Problems

The question of reversibility of sterilization came up repeatedly in the course of the meeting. It was reported that some men and women were indicating a desire for restoration of fertility in as short a time as six months following sterilization. Therefore, several speakers warned, there is an urgent need to select the patient carefully, either for tubal ligation or for vasectomy.

Reversible Sterilization

Efforts to restore the fallopian tubes were discussed in reports by: Drs. Celso-Ramon Garcia, of the Department of Obstetrics and Gynecology of the University of Pennsylvania School of Medicine; Alvin M. Siegler, Clinical Professor of Obstetrics and Gynecology at the Downstate Medical Center in New York City; and Thomas H. Clewe, Research Associate at the Division of Reproductive Physiology, Delta Regional Primate Center in Covington, Louisiana. Dr. Garcia emphasized the need to perform ligation in a way that is least damaging to the tube.

To accomplish this, he said that he and his colleagues have been using an operative microscope technique (microsurgery), using very fine suture material. The purpose of this surgery is to do little damage to the tubes while still accomplishing sterilization. Dr. Garcia reported that three of 14 women who had their tubes reconstructed had live births in a three and one-half year period. "We need more careful monitoring of patients who have had this done in order to evaluate the procedure," Dr. Garcia noted.

He added that it appeared that end-to-end reconnections of the tubes "offer most to women who have had tubal ligation."

Warning that "gynecologists will be besieged with requests for reversibility," Dr. Garcia urged that only the minimal possible destruction of the tubes be performed. He declared that little can be done when two-thirds of the tube has been cut away.

Dr. Clewe described tests on rabbits in which silicone-coated tantalum clips were used to close the tube. The clips close but do not cut the tube. He said that the clips are easily placed by means of a single applicator tool, and that the technique causes minimal adhesions or tissue damage. The clasp is easily removed, he said.

Dr. Siegler, commenting on a study of 100 consecutive operations performed on patients to correct sterility caused by tubal disease, observed that lesions of the fallopian tube are responsible for infertility in 50 percent of the cases. The operations were divided into several groups, which included exploratory laparotomies; procedures to accomplish loosening of adhesions in tissues around the uterine tube; reconstruction of one tube; and correction of tubal obstruction by intrauterine pressure injections.

Dr. Siegler said that studies of the results of tubal reconstruction cannot be compared at present despite hundreds of reports because "everybody talks of different things." Only by the "adherence to some common standard can gynecologists compare operative results." The only measure of a successful operative result is "the number of live births that follow, and not postoperative tubal patency rates, abortions, or tubal pregnancies," he said. "Proper selection of patients is a most important factor in influencing results. Some [tubes] are not reconstructible," the physician concluded.

Autoimmune Response

It has been reported in the literature that vasectomy may be followed by autoimmunizing antibodies which may cause infertility even after the vas is repaired successfully, and this problem was discussed by Drs. Edward T. Tyler, Assistant Clinical Professor of Medicine and Obstetrics and Gynecology, at the University of California School of Medicine (Los Angeles); Sidney Shulman, Professor of Microbiology at New York Medical College, and Rudi Ansbacher of the Department of Obstetrics and Gynecology at Brooke General Hospital at Fort Sam Houston, Texas.

Dr. Tyler noted that some studies had indicated that a small but definite percentage of men showed serum antibodies to their own sperm. This appeared to be most common in men who had had vasectomies or who had obstructive types of azoospermia, a condition in which there is an absence of spermatozoa in the semen. He was skeptical about the view of some investigators that condoms should be used by the husband to avoid absorption of sperm antigens by the wife. He will not be convinced, he said, "unless it is demonstrated that these *presumed* sperm antibodies are actually specific *sperm* antigens and that they are shown to have a mechanism of action which can interfere with conception."

Serum antibodies were also reported in post-vasectomized men by Dr. Ansbacher. In an earlier study, he had reported that six months after vasectomy, about half of 55 men had sperm-immobilizing antibodies. His latest study—of 27 of the 55—showed that one year after vasectomy, 40 percent had sperm-immobilizing antibodies. Five of these men showed a significantly higher titer of sperm-immobilizing antibodies one year after vasectomy, while eight men who showed sperm-immobilization antibodies gave a positive allergy history. Dr. Ansbacher added that the incidence of sperm-immobilization in these men after vasectomy is "indicative of a continued stimulus of sperm antibodies." The significance of this is not clear, he continued, "but it may indicate an immunological change after vasectomy, and may show that the procedure may be irreversible when sperm antibodies are formed.

In another report on antibody research, Dr. Shulman said that tests indicated there may be two different types of sperm cells for each male, with each having "different and alternative antigens at some location." He added that it may be assumed "that a sensitized woman may react to one or both of these antigens, but that this does not usually matter, since the test sperm from most men will each be a mixture of both antigen types, in roughly equal amounts."

A follow-up study of 100 women who had had voluntary sterilization shows that long-term effects seem to be "nil," and that such sterilization is followed by improved sexual life. The average followup was at 14 months after sterilization, Dr. Juan Di Musto, Director of the Crittenton Clinics in Detroit, said. The women, whose average age was 31, were personally interviewed by a team headed by Dr. Di Musto, and 90 percent reported that they were pleased with the operation.

Nine out of 10 of the women said they were more relaxed about sexual intercourse and more than half said their libido had increased, according to Dr. Di Musto. Queried as to other psychological after effects of sterilization, more than nine out of 10 women (95 percent) said they had noticed no change in their feelings after the operation. Dr. Di Musto stressed that these had been voluntary sterilizations. [For additional material on sterilization see "Simpler Methods Boost Public Acceptance," *Family Planning Digest*, Vol. 1, No. 2, 1972, p. 3.]

Research, Experience With Prostaglandins

In a discussion of prostaglandins, Dr. Jack Lippes, Associate Professor of Obstetrics and Gynecology at the State University of New York at Buffalo, reported that a study of human fallopian tubal fluid indicated that PG F_{2a} moved from the surface of the tubal mucosa to the lamina propria, a layer of interlacing connective tissue fibers, after ovulation. This suggests endocrine control and the possibility of a feedback mechanism, Dr. Lippes said. "By its vasoconstrictive action on the blood vessels of the ovary, PG F_{2a}, even at low concentrations locally, could cause luteolysis," he noted. "Although this mechanism has been demonstrated in lower mammals, final proof of its existence in man is still lacking."

Seventeen of 20 patients, whose pregnancies were between 14 and 21 weeks gestation, aborted completely when given PG F_{2a} through the intraamniotic route, reported Dr. Anne C. Wentz, Instructor in Gynecology and Obstetrics at the Johns Hopkins University School of Medicine. One woman aborted incompletely, and two failed to abort. Dr. Wentz said that in most cases an initial dose of 25 mg was given, with a total amount up to 70 mg, depending on the patient's response. If the frequency of uterine contractions was less than five per 10-minute period, and/or the average intensity or amplitude of uterine contractions was less than 20 mm of mercury per 10-minute period, additional doses of PGF_{2a} were given via catheter into the amniotic cavity.

Dr. Wentz said that the average time from the start of medication to abortion in those who aborted completely was 22 hours and eight minutes. Average blood loss was 110 cc. Intravenous administration of pitocin was given to 13 patients to produce abortion of the fetus in 11 patients, and expulsion of the placenta alone in an additional two. "Pitocin was used to increase contractile frequency and uterine tonus," Dr. Wentz explained. "However, it was effective only in those patients in whom prostaglandin-induced contractions appeared inadequate to expel the fetal material. PG F_{2a} appears to cause a contraction-like effect upon the cervix."

Dr. Wentz concluded that intraamniotically administered PG F_{2a} is efficient and nontoxic, but is accompanied by side effects. She termed vomiting the only side effect of consequence, and said: "Although not a serious complication, it can be annoying to the patient and responsible for increased utilization of nurse and physician time." The advantage of PG F_{2a} over saline injections seems to be solely in decreased hospital stay, she added. [See "Prostaglandins: New Birth Control Hope or Headache?" *Family Planning Digest*, Vol. 1, No. 2, 1972, p. 11.]

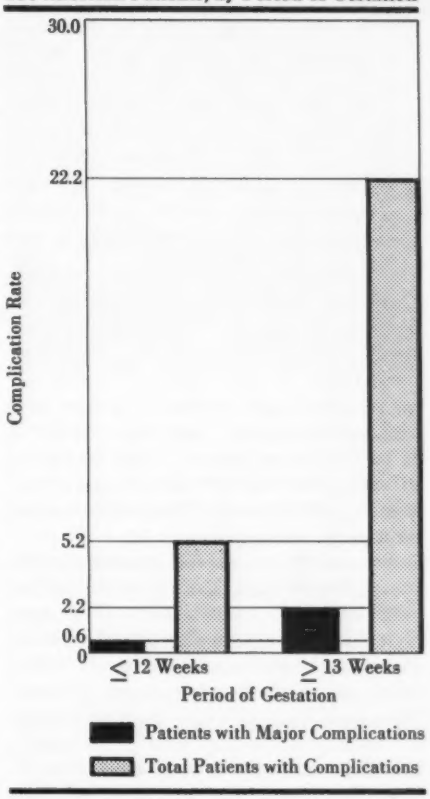
Medical Complications of Legal Abortion One in 20 During First Trimester

The incidence of early medical complications associated with legal first-trimester abortions performed in U.S. hospitals and clinics during 1970-1971 was one in 20, according to Dr. Christopher Tietze, Associate Director of the Biomedical Division of the Population Council. The risk of *major* complications associated with legal first-trimester abortions was one in 200. The risk of major complications was three or four times higher than that, however, if the abortion was performed during the second trimester of pregnancy.

While all women with complications were classified in seven nonoverlapping categories, the more restricted group of "major complications" totaled 765 of 7,039 complications. Thus, major complications constituted one percent of all patients, and 11 percent of all patients with complications. Major complications included all patients receiving unintended major surgery (laparotomy and repair, hysterotomy and hysterectomy); all patients given one or more blood transfusions; all patients with three or more days of fever, and other categories connected with comparable degrees of risk of death, long illness or permanent functional impairment. About 74 percent of the abortions were performed in the first trimester; almost one-fourth of all abortions were performed at eight weeks' gestation or earlier and one-half at nine to 12 weeks. Late abortions were most frequent among women under 18 years of age, nonprivate patients, black women and mothers of six or more children.

Dr. Tietze said that complication rates for abortions on hospital outpatients or those in freestanding clinics appeared to be lower than rates for abortions performed on inpatients. Complication rates were lowest for abortion by suction, followed, in ascending order, by classical D & C (dilatation and curettage), saline, hysterotomy and hysterectomy. The complication rates for abortions by suction were lowest at seven to eight weeks' gestation, from which they rose steadily to 15 weeks or more. The number of abortions covered by the Joint Program for the Study of Abortion, set up by The Population Council, was 72,988. Of these, 80 percent took place in hospitals, and 20 percent in clinics. There were six deaths and all but one involved abortions in the second trimester. Dr. Tietze pointed out that the overall mortality rate was 8.2 per 100,000 abortions. This compared with 25.5 per 100,000 in England and Wales for 1968-1969; 18.1 per 100,000 in Sweden for the middle 1960s; but only 2.2 per 100,000 in Czechoslovakia for 1962-1966 and 1.0 per 100,000 in Hungary for the period 1964-1969. "These differences in abortion-related mortality reflect, to a large extent," he said, "the different proportions of late abortions in these countries. In Czechoslovakia and Hungary, elective abortions must, by law, be performed during the first trimester of pregnancy.

Figure 1. Total and Major Complications per 100 Abortion Patients, by Period of Gestation



Of the total number of abortions, single women represented 56 percent, currently married women, 30 percent and previously married women, 14 percent. White women totaled 69 percent, black women, 26 percent, and other ethnic groups, chiefly Puerto Rican and Oriental, five percent. The number of patients who were black, married, had been pregnant before and who were nonprivate patients increased during the year of study. Dr. Tietze said that suction was the operative procedure used for 92.8 percent of all abortions in the first trimester, and that instillation of saline was used in 94.5 percent of all terminations at 17 weeks or later.

Ethics of Human Experimentation

Ethical problems in the use of human subjects for biomedical research were explored at the Society's meeting as a consequence of the development in recent years of new, experimental chemical and surgical methods to accomplish fertility control, sterilization, abortion and to treat infertility. Bernard Barber, Professor of Sociology at Columbia University, reported on two detailed studies of the view of scientists themselves on the ethical problems as they perceived them. The two studies involved responses to questionnaires mailed to 293 biomedical research institutions and 352 personal interviews carried out at a university hospital and research center, typical of many where investigations utilizing human beings are carried out, and at a community and teaching hospital affiliated with a medical school, another quite typical setting for research.

Seek Data on 2 Key Issues

The investigators sought data on two key issues, informed consent and risk-benefit ratios. They found that "the majority of researchers . . . are very much aware of the importance of informed voluntary consent, that they express unwillingness to take undue risk . . . and that they do not themselves actually do studies in which the risk-benefit ratio is unfavorable for their patient-subjects. But the evidence also shows, unfortunately, that there is a significant minority that is more permissive. . . ." Barber also found that poor patients were much more often selected as subjects in studies with "unfavorable risk-benefit ratios." Dr. Barber attributed the motivation for the lower ethical standards to a desire for recognition and prestige for "priority of discovery."

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R. Ansbacher, M.D., and J. C. Wurster, M.D., "Further Observations on Sperm Antibodies in Vasectomized Men."

B. Barber, J. Lally, J. Makarushka and D. Sullivan, "Experimenting with Humans: Problems and Processes of Social Control in the Biomedical Research Community."

S. S. Ogra, K. T. Kirton and J. Lippes, M.D., "Prostaglandins and the Human Fallopian Tubes."

S. N. Preston, M.D., "A Report of a Collaborative Dose-Response Clinical Study Using Decreasing Doses of Combination Oral Contraceptives."

S. Shulman and E. Lewin, "Human Spermaglutinating Activity in Different Tests."

C. Tietze, M.D., and S. Lewit, "Early Medical Complications of Legal Abortion: Highlights of the Joint Program for the Study of Abortion."

E. T. Tyler, M.D., "Where Do We Stand on Immunological Factors in Infertility?"

A. C. Wentz, M.D., I. M. Cushner, M.D., and G. S. Jones, M.D., "Efficacy of PGF_2 alpha as an Abortifacient Agent in Early Pregnancy."

R. Ansbacher, M.D., personal communication.

J. Di Musto, personal communication.

Program Design

Coordinated Approach Essential for Success

"When a number of agencies are trying independently to meet the needs of essentially the same target population, interagency competition (or even simple absence of active interagency cooperation) is highly dysfunctional," write health administration specialists James E. Allen and Sagar C. Jain of the University of North Carolina in a recent article analyzing family planning programs in the United States.

When family planning services were provided largely by Planned Parenthood and local health departments, as was the case for about half a century after 1916 when the first birth control clinic was opened by Margaret Sanger, the need for cooperation in the delivery of such services was hardly urgent, the authors observe. For most of that period, family planning was considered only a minor part of maternal and child health care and it was reasonable that leadership for provision of services was assumed by health departments, where both a pool of physicians and potential consumers of family planning were located.

However, Allen and Jain point out, when the link between poverty and family size was documented, when the personal and social consequences of uncontrolled or inadequately controlled fertility were assessed and acknowledged and when concern about population growth rates developed, family planning became "a national goal with emphasis on comprehensive programs instead of on small isolated efforts." The federal government began to channel increasing funds into family planning and, whereas from 1937 to 1964 only a state health agency could obtain federal funds for family planning services, the Economic Opportunity Act of (December) 1964 broadened eligibility for federal funding to local voluntary agencies. By 1966, any "designated state agency," according to the authors, "could get 53 to 83 percent federal matching money for family planning for all recipients of public assistance and other medically indigent persons under Title XIX (Medicaid). Title IV-A of the Social Security amendments of 1967 "carried control over family planning moneys one crucial step further. . . ."

Infusion of federal funds and the involvement of many more agencies resulted in a notable increase in the number of women obtaining subsidized family planning services, the authors point out, citing the OEO study, *Need for Subsidized Family Planning Services: United States, Each State and County, 1968.* Nonetheless, the authors state, the study showed that "85 percent of the need across America remained unmet. Evidence is accumulating that no one agency has been able to provide full family planning services to the community or even to those persons identified as medically indigent."

One of the key problems, according to the authors, is that:

> . . . most of the agencies participating in family planning tend to compete with each other in delivering services. An OEO family planning project may or may not include the public health department. Physicians may be hired to run an OEO clinic independent of, or even in competition with, existing health department clinics. The same situation may also exist in a family planning program sponsored by a welfare agency, and hospital-based clinics are usually self-contained, staffed by their own nurses and clinicians. Sometimes two or three agencies, each cultivating its own clientele, run separate clinics.

Concluding that such competition is "dysfunctional," Allen and Jain emphasize the need for a multiagency approach to the administration of public family planning programs. They point out that only a few such multiagency programs have been developed, in part because of inertia, in part because of difficulties in "resolving domain problems" and in part because of uncertainty about what ought to be done.

Examining some existing multiagency programs, they note that there is no one pattern suitable for all communities. They agree with Planned Parenthood's Center for Family Planning Program Development (CFPPD), which pioneered the multiagency approach, "that leadership will vary from community to community in response to the unique conditions and centers of power." Thus, in Los Angeles, they point out, CFPPD "helped form a new corporation with board representatives from each participating agency. In contrast, in Newark and Dallas the central administrative functions were located in medical schools."

The authors summarize the fundamentals of multiagency design as follows:

- A core staff separate from the provider agencies should perform "some of the administrative and think-tank functions required for a communitywide effort."
- A communitywide effort should involve major agencies such as the health and social service departments, local hospitals, Community Action Programs of OEO and voluntary groups, among others.
- The central functions of the coordinating agency should include administration, education, patient recruitment and follow-up evaluation and record keeping.

Source

J. E. Allen and S. C. Jain, "Multiagency Participation in Family Planning Administration," *HSMHA Health Reports,* 86:699, 1971.

KAP Study

Small Town Pa. Women Want Clinic

Women living in rural Huntingdon County, Pennsylvania—most of them white and a majority medically indigent—overwhelmingly favor birth control and support the establishment of a publicly supported family planning clinic there, where one does not now exist. Many of the sexually active women of childbearing age say they would use the clinic themselves to prevent unwanted pregnancies. Less than one-third of them currently are using effective contraception to do so. These are the conclusions of a survey made in mid-1971 by Planned Parenthood's Research Department in cooperation with the Altoona Hospital Family Planning Center. They were responding to the state's Turnpike Planning Commission which was assessing the priority economic, social and health needs of various communities. Attitudes toward birth control and family planning and contraceptive practices of women residents 18-44 years of age were studied. The sample included 152 women, 12 of them college students, from low-income areas of three townships: Mt. Union, Alexandria and Huntingdon. Every third household within the survey area containing a woman of appropriate age was interviewed.

Nine out of 10 of the women in the survey group were white, only six percent were black; 75 percent were Protestant and 12 percent were Catholic. Fifty-one percent were younger than 30 years of age, 66 percent had finished high school or had had some college education and 71 percent had lived in the county for at least 10 years. Medical indigency was assumed for 54 percent, based on the income/family-size relationship. A majority of the respondents—66 percent—were married, 15 percent were single and 19 percent were separated, divorced or widowed. Nearly half of the 85 percent who had been pregnant at least once either had not wanted their last pregnancy or could not say whether or not they had wanted it.

Use of Contraception

Just over one-fifth (22 percent) of the respondents, 33 women of the total of 152, reported that they could not become pregnant either because they had had tubal ligations or hysterectomies, or their husbands had had vasectomies, or because they were naturally infertile. In addition, 35 women were not considered at risk when the survey was done because of sexual inactivity, pregnancy or the desire to become pregnant. This left 84 women, 55 percent of the total group, who were fertile, sexually active and not desirous of pregnancy. The survey revealed that about one-half—only 44 of those at risk—were

currently practicing birth control, and of these only 26 women were using a medical method of contraception; a nonmedical method was being used by 18 women. In addition, 40 sexually active women who did not wish to become pregnant were not using any form of contraception. This was almost 48 percent of those at risk.

Forty-three percent of the whole group and 55 percent of the 84 women considered in need of contraception at the time of the survey said they would attend a clinic in the county.

The oral contraceptive was preferred by 18 women using a medical method, six women were using IUDs and two were using diaphragms. These had been obtained from private physicians in 22 cases, and from a clinic outside of Huntingdon County in the remainder. The survey noted:

> It is probable that the women obtain their medical method prescription from a physician they usually see for general health care, most likely the family physician. Three-fourths of all women interviewed see a physician in their own township when sick; 90 percent usually see a private physician. A large majority of the women (68 percent) utilize the only hospital within the township, J. C. Blair Hospital, for emergency care (deliveries, accidents, operations).

The women in need of contraception but either using nothing or using a nonmedical method—condom, foam, rhythm and douche—had various reasons for their practice. Religious or ideological objections to birth control were cited by seven women, health concerns or dissatisfaction with the pill were mentioned by five and 28 had "ambiguous and undefined reasons."

Knowledge of Contraception

Almost the entire group of women (91 percent) had "heard" about at least one contraceptive method—for 88 percent of these it was the pill. When asked if they knew of a second method, 43 percent mentioned the IUD, 36 percent the diaphragm. When multiple responses were combined, it was found that both pill and IUD were mentioned by 42 percent, pill and another method by 43 percent. These figures are seen as evidence of "a fairly good awareness of the medical methods available," especially in the absence of a clinic as a source of information.

More than half the women interviewed who had heard or read about the pill felt it was not a good method of birth control because of possible "side effects." The survey team also reported that 23 percent of the women had once used the pill but had either stopped or adopted some other method.

The concept of voluntary birth control was accepted by most women. In each of the

townships at least 80 percent of the women approved, in principle, of couples using birth control to plan the number and timing of their children, and 70 percent felt that unmarried college students should also have access to birth control services. Some two-thirds of married women said that their husbands wanted them to practice birth control.

When the questions shifted from the abstract "How do you feel about birth control?" to the more specific "Would you be interested in attending a family planning clinic?," 43 percent of respondents answered "Yes." About half the women who said "No, not interested" were sterile and would have had no personal need for such a service.

The one hospital was believed to be a convenient location for a family planning clinic by almost all the women, although some felt that transportation or babysitting needs might present problems.

A clue to the need for educational programs and the direction these should take came from questions as to the sources of information used by the women. One-quarter had not discussed birth control either with their husbands, friends or clergymen and fully one-half had not discussed the question with a private physician.

This survey appears to support the belief of the Advisory Committee to the Child Health Development Program of the Turnpike Commission that a family planning clinic should have highest consideration among community needs in the county, the researchers report.

According to the Office of Economic Opportunity study, *Need for Subsidized Family Planning Services: United States, Each State and County, 1969*, there were 1,567 women estimated to be in need of family planning assistance in Huntingdon County. Applying the various data obtained from the small household survey reported here, over 1,000 women might be assumed to be currently using nonmedical contraceptive methods or none at all, and close to 800 would attend a family planning clinic were one to be set up in the existing county hospital. Despite such evidence of support, no organized family planning services had been made available as of this account, which was written in July 1972.

Source

"Huntingdon County Family Planning Survey, 1971," Planned Parenthood-World Population, Research Department (mimeo).

Fertility

1971's Young Wives Want Fewer Children

Young wives in the prime childbearing years —18-24—appear to want substantially fewer children than did comparable women in the recent past. In the sharpest decline since 1955, the average number of total births they expected dropped between 1967 and 1971 from 2.9 to 2.4, according to a recent Census Bureau report. "This is the first time since 1955, when birth expectations data were first collected nationally, that the figure has been substantially below 3.0," the Bureau noted. A similar decline in total births expected was found for wives aged 18-39 years, from an average of 3.1 in 1967 to 2.8 in 1971. The Census Bureau attributed this decline to a drop both in fertility to date and in additional number of births expected.

The latest birth expectation figure is in contrast with the 1965 National Fertility Study finding of a birth expectation of 3.4. Still another study, made among women who gave birth during 1964-1966, showed that they had, on the average, 2.78 living children, and an expectation of 0.95 additional children, making an average of an expected 3.73 in completed families.

The Census Bureau survey also showed that the number of young wives who expect two children or fewer has risen from 44 percent in 1967 to 64 percent in 1971. The decline in fertility was indicated in the drop of births to date for wives 18-24 years old from 1.2 to 1.0, and a decline in additional births expected from 1.7 to 1.4. Wives in the 18-39-year-old group already had three-quarters of their total expected births. About two-thirds of wives 18-39 years old and one-quarter aged 18-24 expect no more births, the survey found.

Between 1960 and 1971, there was a sharp decline in the average number of children ever born among women in the 15-24-year

age group, reflecting the drop in fertility in the 1960s. On the other hand, women in the 35-49-year-old group showed an increase between 1960 and 1971 in the average number of children ever born. This took place as women who passed many of their childbearing years during the low fertility period of the Depression and the Second World War were replaced by women who had children during the baby boom of the late 1940s and 1950s.

The Census Bureau said that the median age at first marriage for women between 1960 and 1971 rose from 20.3 to 20.9, while the proportion of those single (never-married) among women 20-24 years old rose from 28 percent to 37 percent. The Bureau noted that about half of all women in the 18-24-year-old group have never been married, and that the u'timate fertility of these women probably will be lower than the ultimate fertility of the ever-married women in the 18-24 age group. This is because of the inverse relationship between age at first marriage and fertility.

A 1964-1966 study, reported by the National Center for Health Statistics (NCHS), examined differentials in expectations of additional children, according to selected characteristics such as income, education and geographical location. Mothers of one child where family income or education of father was higher, who were employed during pregnancy, who were white, or who lived outside of the South were more likely to expect additional children than those with low family incomes and low education of father, who were not employed, were black, or were residents of the South.

The expectation of more children changed when there were three children in the family. In this situation, low-income mothers who did not work during pregnancy, who were black and whose husbands had little education expected more children than did white high-income women who were employed during pregnancy and whose husbands received more education.

The NCHS said that "there was no clear indication that in the early stages of family formation mothers with low incomes expected to have larger families than those with high incomes." The expectation of additional children was about the same in number among mothers of one or two living children, regardless of income.

The NCHS pointed to other data showing that couples in the lower socioeconomic group are less likely to use contraception than those in the higher socioeconomic group and "are less likely to be successful users even if they have tried contraception."

Sources

"Birth Expectations Data: June 1971," *Current Population Reports*, Series P-20, No. 232, Feb. 1972.

National Center for Health Statistics, "Differentials in Expectation of Additional Children among Mothers of Legitimate Live Births, United States, 1964-1966," *Vital and Health Statistics*, Series 22, No. 13, Feb. 1972.

N. B. Ryder and C. F. Westoff, *Reproduction in the United States 1965*, Princeton University Press; 1971, Table IV-1, p. 54.

Frozen Sperm

MD Group Cautions Men on Semen Banks

Commercial Notices

THINKING about a vasectomy? Call the sperm bank first. For information or appointment, Genetic Laboratories. Inc., 344 East 67 St., N.Y., N.Y. (212) 472-1590.

Despite reservations by public health experts about the efficacy of *long-term* freezing of human sperm as fertility insurance [See *Digest*, Vol. 1, No. 3, 1972, p. 5], advertisements like the above, appearing almost daily in *The New York Times* and other newspapers across the country, continue to suggest that sperm banking does represent a sure means of reversing sterilization for vasectomized men. Commercial sperm banks, operating for profit without any legal constraints, are springing up in many communities, and the two major banks, Idant and Genetic Laboratories, Inc., with facilities in 10 major U.S. cities, have recently merged.

Spurred by this unrestricted growth, the National Medical Committee of Planned Parenthood-World Population (PP-WP) has warned its affiliates against the use of human semen banks at this time. It has also alerted Secretary Elliott Richardson of the Department of Health, Education and Welfare, Dr. Charles Edwards, Commissioner of the Food and Drug Administration, as well as the National Academy of Sciences and the New York City Department of Health to the need for detailed study of the "societal, moral, ethical, legal and medical questions raised by human semen cryobanking [freezing and storage], particularly as to regulation by official agencies." In a related development, the Committee on Health of the New York State Assembly plans to introduce a bill at the next session of the State Legislature empowering the State Health Commissioner to establish regulations governing the collection, processing and storage of human semen and the operation of the banks.

In its statement, the PP-WP National Medical Committee pointed out that "the techniques now used for frozen human semen storage do not appear to justify the unrestricted use in clinical practice of specimens *more than three years old*" (emphasis added). The Committee criticized the commercial semen banks' suggestion that men about to have vasectomies store their semen as fertility insurance. The promise of insurance by such storage may be "misleading," and "moreover, it may lead to the persuasion of immature or poorly motivated individuals to undergo vasectomy," the Committee said.

It also observed:

> the suggested use of semen cryobanking for the purpose of circumventing oligospermia [too few sperm in the semen] by collecting successive specimens from husbands in infertile marriages for eventual concentration and . . . insemination is without merit. On the basis of considerable experience, various experts feel that semen quality incapable of producing conception under normal physiological circumstances is not likely to survive the freezing process.

Some areas of concern deserving special study, according to the Committee, are: overuse of donors for artificial donor insemination in small communities, preservation of confidentiality, effect of commercial banks on the physician-donor-recipient relationship and method of recordkeeping. It urged that a task force be formed "at the highest level" to consider all the implications of long-term freezing of human sperm.

The commercial fees for sperm freezing range from $80 to about $150 per donor with an additional annual fee of about $18 for storage. (The storage fee is reduced for prepayment for three or 10 years).

The leading banks, while strongly suggesting that, as one of them expresses it in its public relations material, storage of sperm "can considerably improve [a man's] chances of having children while enjoying the benefits of simple and effective birth control [vasectomy]," are careful to qualify this promise. Idant's material says, ". . . though we think that fertility can be maintained for many years, we cannot guarantee this in the case of a particular individual." Genetic Labs states, "Assuming that there is adequate viability after freezing, 36 vials [of frozen sperm] should give the individual a good statistical probability of having his own children."

Spokesmen for both laboratories told *Digest* that they favor legislation to maintain quality control and proper storage, testing and handling techniques.

Sources

Advertisement, *The New York Times*, July 12, 1972.

Committee on Health of the New York State Assembly, draft of proposed New York State bill entitled, "An Act to Amend the Public Health Law, in Relation to Approval of Semen Banks."

Genetic Laboratories, Inc., letter to prospective client describing services, April 6, 1972.

Idant Corporation, letter to prospective client describing services, April 12, 1972.

J. A. Silbert, M.D., Idant Corporation, personal communication.

National Medical Committee, Planned Parenthood-World Population, "Human Semen Cryobanking," and "The Need for Regulation of Human Semen Cryobanks," March 29, 1972.

Family Planning Job Opportunities

Family planning agencies are invited to send job opportunity statements for professional positions to:

National Center for Family Planning Services
HSMHA, DHEW
5600 Fishers Lane, Room 12A-33
Rockville, Maryland 20852

The National Center for Family Planning Services, HSMHA, does not necessarily support the agencies seeking to fill positions.

All openings listed below are with Equal Opportunity employers.

Position: Executive Director
Agency: Association for Voluntary Sterilization
Location: New York, N.Y.
Salary Range: $25,000-$30,000, good fringe benefits
Job Description: Administration of a small office with a staff of 12-14; investigating new programs and techniques in all areas of voluntary sterilization so that agency may become a national information center; being informed on research projects and their funding; evaluating new applications; originating and supervising efforts to further educate physicians (including medical students) and laymen; dealing with various government agencies; cooperation with a new office to originate voluntary sterilization programs in less developed countries.
Qualifications: M.D. or Ph.D. specializing in population affairs. Appropriate scientific or public health background. Administrative experience plus a knowledge of the role of sterilization as a health service in family planning and population.
Contact: Joseph E. Davis, New York Medical College, 1 East 106th Street, New York, New York 10029

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Position: Physician
Agency: Committee for Economic Opportunity, Inc.
Location: Nogales, Ariz.
Salary: $30,000
Job Description: Position to be funded under an Office of Economic Opportunity Family Planning Demonstration grant from July 1, 1972 through March 31, 1974. Physician will be responsible for establishing and staffing family planning, prenatal, postpartum, well-child and other clinics as need arises. Clinics will be established at the Santa Cruz County Health Department.
Qualifications: M.D., licensed to practice in Arizona; experience in working with low-income individuals; experience in community medicine and ability to speak Spanish preferred; some administrative background.
Contact: Resumé to Barbara Altman, Planning and Program Development Director, Committee for Economic Opportunity, Inc., 721 North Fourth Avenue, Tucson, Arizona 85705. Telephone 602-622-4896

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Position: Chief Public Health Nurse
Agency: University of Nebraska Medical Center
Location: Omaha, Nebr.
Job Description: Assume supervisory capacity in a medical center in a department chiefly concerned with maternal and child care.
Qualifications: Nursing degree, M.P.H., with preference given to experience in the field.
Contact: Janet Baker, Personnel Assistant, Unisity of Nebraska Medical Center, 42nd and Dewey Avenue, Omaha, Nebr. 68105

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Position: Social Work Consultant
Agency: New Hampshire Bureau of Maternal and Child Health, Family Planning Program
Location: Concord, N.H.
Salary Range: $9,100-$13,022
Job Description: As part of multidisciplinary state core team, participate in program planning and policy development, provide ongoing case and program consultation to social workers and outreach workers in six local clinics.
Qualifications: M.S.W. and two years' experience. Prefer mix of clinical and supervisory experience, especially in public health.
Contact: Bonnie Jack, New Hampshire Family Planning Program, Department of Health and Welfare, Division of Public Health, 61 South Spring Street, Concord, N.H. 03301

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Position: Director of Information, Education and communications
Agency: Family Planning International Assistance, Planned Parenthood-World Population
Location: New York, N.Y.
Salary Range: $20,000-27,500
Job Description: Manager of all information, education and communications project activities; design, plan and direct development and implementation of program assistance for local family planning programs in developing countries worldwide.
Qualifications: Extensive experience in management of information, education and communications activities; strong interpersonal and cross-cultural skills, available for international travel.
Contact: John Palmer Smith, Family Planning International Assistance, 810 Seventh Avenue, New York, New York. 10019

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Position: Assistant to the Chief Executive Officer
Agency: Planned Parenthood-World Population
Location: New York, N.Y.
Salary Range: Starting upward of $14,000.
Job Description: Serve as the Chief Executive Officer's delegate in developing special projects internal to the Federation, which involve more than one group of PP-WP departments, and coordinating staff, Board and affiliate efforts in carrying out these projects. Develop a role as "ombudsman" for the affiliates.
Qualifications: Strong administrative experience; first rate writing skills; experience in the field of family planning.
Contact: Personnel Department, 810 Seventh Avenue, New York, N.Y. 10019

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Position: Medical Director
Agency: Planned Parenthood Association of Phoenix
Location: Phoenix, Arizona
Salary: $25,000
Job Description: Coordinate with affiliate staff and medical advisory committee; supervise medical aspects of operations; examine patients and provide consultation; perform sterilizations; serve as liaison with medical community; participate in educational activities.
Qualification: M.D. licensed to practice in Arizona, preferably with OB-GYN speciality; qualified in tubal laparoscopic procedure.
Contact: Joe Davis, Executive Director: Planned Parenthood Association of Phoenix, 1200 South Fifth Avenue, Phoenix, Ariz. 85003

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Position: Director of Training
Agency: Planned Parenthood of New York City Resources Center
Location: Brooklyn, N.Y.
Salary Range: From $17,000
Job Description: Develop new training programs; serve on program planning committee along with key staff members including the physician in charge, the clinic director and the coordinator of social services; coordinate and integrate all training programs; hire, train and supervise project coordinators and core training staff.
Qualifications: Graduate degree preferred in: Human Relations, Education, Human Sexuality, Social Work, Health Education or Guidance and Counseling. Experience in supervision and program planning; knowledge of new developments and techiques.
Contact: Marian Levy, Personnel Director, Planned Parenthood of New York City, 300 Park Avenue South, New York, N.Y. 10019

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Position: Executive Director
Agency: Planned Parenthood of Santa Clara County
Location: San José, Calif.
Salary Range: $14,000-$18,000
Job Description: Responsible for the operation of the office staff as well as two clinics, and for the implementation of educational and community services for county-wide program. Total staff of 25, and current budget approximately $250,000. Position requires attendance at committee and board meetings, in addition to administrative responsibilities during normal office hours.
Qualifications: A minimum of two years' supervisory experience including hiring, scheduling, performance reviews, and a college degree or equivalent. Background in administration in the social services, public health, education or related fields preferred; background with an agency that utilizes volunteers. Driver's license and a car are necessary.
Contact: James G. Little, Chairman, Personnel Committee, Planned Parenthood Association of Santa Clara County, 28 North 16th Street, San José, Calif. 95112

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Position: Clinical Social Worker III
Agency: South Carolina State Board of Health
Location: Columbia, S.C.
Salary Range: $10,610-$14,555
Qualifications: M.S.W. plus four years social work experience, at least two in a clinical setting.

Position: Clinical Social Worker I
Agency: Appalachia II Public Health District
Location: Greenville, S.C.
Salary Range: $8,525-$11,595
Qualification: M.S.W.

Position: Clinical Social Worker I
Agency: Lower Savannah Public Health District
Location: Aiken, S.C.
Salary Range: $8525-$11,595
Qualification: M.S.W.
Contact: For the three positions above, Office of Social Work, State Board of Health, J. Marion Sims Bldg., 2600 Bull St., Columbia, S.C. 29201

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Position: Nurse Supervisor
Agency: United Migrant Opportunity Services, Inc.
Location: Milwaukee, Wisc.
Salary Range: $9,000-$10,000
Job Description: Supervise and participate in the delivery of family planning and related educational and medical services in one or more clinic settings. Assist and supervise staff in medical and technical program areas, training, public relations, and outreach activities.
Qualifications: R.N.; ability to work effectively with minority and low-income people in Spanish American program; prior supervisory experience. Nurse specialist in family planning, or nurse practitioner preferred.
Contact: Ellen Elfner, Family Planning Program Director, United Migrant Opportunity Services, Inc., 809 West Greenfield Avenue, Milwaukee, Wisc. 53204.

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National Center for Family Planning Services
Health Services and Mental Health Administration
Department of Health, Education and Welfare
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Teenage Mothers

Children Affected by Mothers' Adolescence

Mothers younger than 18 years of age seem less capable of nurturing their children effectively than mothers 18 years of age and older. This is a tentative conclusion of a public health team that examined a variety of data concerning the physical and psychological development of 172 Baltimore children matched for such variables as socioeconomic status, birth weight of the child, number of previous live births of the mother and race of the mother.

Social and psychological data were collected when the children were aged six to eight, and again when they were eight to 10 years of age. Stanford-Binet and Wechsler IQ scores and Wide-Range Reading Achievement Test grade levels were derived from individually administered psychological tests. Emotional adjustment and personality traits of the children were rated by a psychologist, while measures of mother-child relationships (using the Maternal Behavior Research Instrument), bedwetting status and socioeconomic data were derived from social work home interviews.

Among the more significant findings, according to the investigators, were the following:

- Children born to younger mothers were less likely to be living with both parents six to eight years after birth than children born to older mothers. Only 20 of 86 children of the first group lived with both parents continuously with no separation longer than one year, compared to 43 children in the second group.
- The younger mothers had significantly more children six to eight years after the birth of the study child than did the older mothers. They had an average of 3.45 children compared to 2.93 for the older mothers. Moreover, the younger mothers lived in households which were significantly larger than did the older mothers.
- The younger mothers were rated as less anxious and more likely to think that their six- to eight-year-old children should be free to act independently than did the older mothers. They also appeared to have a less intense emotional and behavioral involvement with their children. In addition, the younger mothers, according to the test instrument, were "less likely . . . to wish to control [the children], to keep them closely attached to themselves, and also were less likely to have intellectual interests."
- The children of younger mothers had a significantly lower mean height.
- Although the children of the older mothers attained a more advanced reading level, there was no significant difference in IQ between the two groups of children. Similarly, there was no significant difference in bedwetting.
- The two groups of children were rated by the psychologist as normally adjusted, but there were differences in the type of psychiatric disturbance when there was such. Children of younger mothers were rated as having acting out or infantile difficulties, while children of older mothers suffered damage to their self-esteem. While the children in the first group were more often rated as outgoing, they were also more often rated as more dependent and more distractible. There were no differences, the tests indicated, in the following nine personality traits: anxiety, tension, rigidity, fears of failure, aggressiveness, sensitivity, withdrawal, sullenness and suppression of feeling.

The investigators maintain that "the study findings support a contention that the youth of mothers is a contributing factor to less adequate nurture of children. . . ."

Source

W. C. Oppel and A. B. Royston, "Teen-Age Births: Some Social, Psychological, and Physical Sequelae," *American Journal of Public Health*, 61:751, 1971.

Credits

pp.1,2,9,13: Ken Heyman; p.3: Frontier Nursing Service; p.5: Bonnie Freer; p.6: Gordon Baer, Black Star; p.8: Carl Purcill, AID; p.16: Dennis Stock, Magnum; Chart on p.11 by Michael Firpo.

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